

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

BOTOX_(botulism toxin type A)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext.and options _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- ▶ Used for patients age 12 and above
- ▶ Botox may be used only after 2 other muscle relaxants have been tried and failed .
- ▶ **Approved for DOCUMENTED diagnosis of:**
 1. Cervical dystonia
 2. To decrease severity of neck pain in adults
 3. Decrease severity of abnormal head position
 4. Strabismus
 5. Blepharospasm or VII nerve disorders.

Non Covered Use:

1. Primary axillary hyperhidrosis
2. Cosmetic procedures
3. Spasticity

Information:

This product is available for physician use in the office with J code: J0585 or through a pharmacy with prior authorization.

Treatment is every 3 months

Cumulative dose not to exceed 200 units within 30 days

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

6 months with documentation of progress of patient.